

## CERTIFICATE OF DEATH

Reg. Dist. No.

13741

13768

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Harford</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Evans</b> Last <b>Baker</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>26,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1869</b>
9. AGE (In years last birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Foreman. Penna. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Goodwin Baker</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Lamar</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>W. Ernest Baker, Havre de Grace, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Chronic Myocarditis - Chronic Endocarditis</b> DUE TO (b) <b>Chronic Endocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Chronic Endocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 17, 1959</b> to <b>Dec 26, 1959</b> , that I last saw the deceased alive on <b>Dec 26, 1959</b> and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence I. Benson, M.D.</b>		ADDRESS (Street, city or town, state) <b>Port Bf. Rd., Perryville, Md.</b> DATE SIGNED <b>12/26</b>	
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-30-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Principio Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Principio Furnace, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>See a. Patterson &amp; Son, Perryville, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

80711

April 1951

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13769

## CERTIFICATE OF DEATH

Reg. Dist. No.

13742

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>15 minutes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>		e. STREET ADDRESS <b>15 HANOVER</b>	
3. NAME OF DECEASED (Type or print) <b>ETA ROSE BANKS</b>		4. DATE OF DEATH <b>DECEMBER 10 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLOR</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE BANKS</b>		14. MOTHER'S M maiden NAME <b>SALLY McGAW</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>833 N. Fayette</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b> DUE TO (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/4</b> , 19 <b>58</b> , to <b>12/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/10</b> , 19 <b>59</b> , and that death occurred at <b>5:55</b> A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George T. Stansbury</b> M.D.		DATE SIGNED <b>12/10/59</b>	
PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>		ADDRESS (Street, city or town, state) <b>569 Revolution St. Harford, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R.D. Bel Air, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b> ADDRESS <b>Tarring Funeral Home, Aberdeen, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO BE RELIED ON BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13784

## CERTIFICATE OF DEATH

Reg. Dist. No.

13743

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Forest Hill</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Walters Mill Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>B.</b> Last <b>Bedsaul</b>		4. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-30-7221</b>	
17. INFORMANT <b>William M. Bedsaul, Rd. Box 307, Forest Hill, Md.</b>		Address <b>R.D.#7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis ?</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October</b> , 1929, to <b>December 8</b> , 1959, that I last saw the deceased alive on <b>December 7</b> , 1959, and that death occurred at <b>6:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Forest Hill, Maryland</b> DATE SIGNED <b>December 8, 1959</b>			
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D. <b>Forest Hill, Maryland</b> <b>December 8, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Foster, Bel Air, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

CERTIFICATE OF DEATH

1918

1

Name of Deceased ... ..		Date of Death ... ..	
Sex ... ..		Age ... ..	
Race ... ..		Birth Date ... ..	
Place of Birth ... ..		Usual Residence ... ..	
Cause of Death ... ..		Manner of Death ... ..	
Physician's Signature ... ..		Registrar's Signature ... ..	
Date of Certificate ... ..		Place of Death ... ..	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the place where the death occurred.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 14 Film 6253 12-29-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

13744

13770

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN lb <u>45 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAVERDE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>071 HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>628 N. ADAMS ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BARBARA</u> <u>BRAD</u> <u>FIELD</u>				4. DATE OF DEATH Month Day Year <u>December</u> <u>13</u> <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?-?-1868</u>		9. AGE (In years last birthday) yrs. <u>91</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Michael Hutchinson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>572.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture sigmoid colon</u> DUE TO (c) <u>Ulcerative colitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 29, 1959</u> , to <u>December 13, 1959</u> , that I last saw the deceased alive on <u>December 12, 1959</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M.C. Finney</u>				ADDRESS (Street, city or town, state) <u>504 Lewis St., Haverde Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James M.C. Finney</u>				DATE SIGNED <u>12-14-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/15/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Baron Han de Chen Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1875

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly mirrored and difficult to decipher.]*



13771

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanover</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>	
c. LENGTH OF STAY IN 1b <i>49 yrs.</i>		d. STREET ADDRESS <i>300 Superior</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carmine Lionelli</i>		4. DATE OF DEATH <i>12/21/59</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 3, 1878</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Italy</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Theresa Hamell, Hanover, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardiac Decompensation</i> DUE TO (c) <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/20</i> , 19 <i>59</i> , to <i>12/21</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/21</i> , 19 <i>59</i> , and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. H. Woodhewer</i>		ADDRESS (Street, city or town, state) <i>407 S. ONION</i>	
PHYSICIAN'S NAME (Type) <i>Wm. H. Woodhewer</i>		DATE SIGNED <i>12/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12/24/59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Eun</i>		22d. LOCATION (City, town, or county) (State) <i>Hanover, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. H. Woodhewer</i>		ADDRESS <i>407 S. ONION</i>	
24a. REC'D BY REGISTRAR <i>DEC 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**A 1 X**  
FOR STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

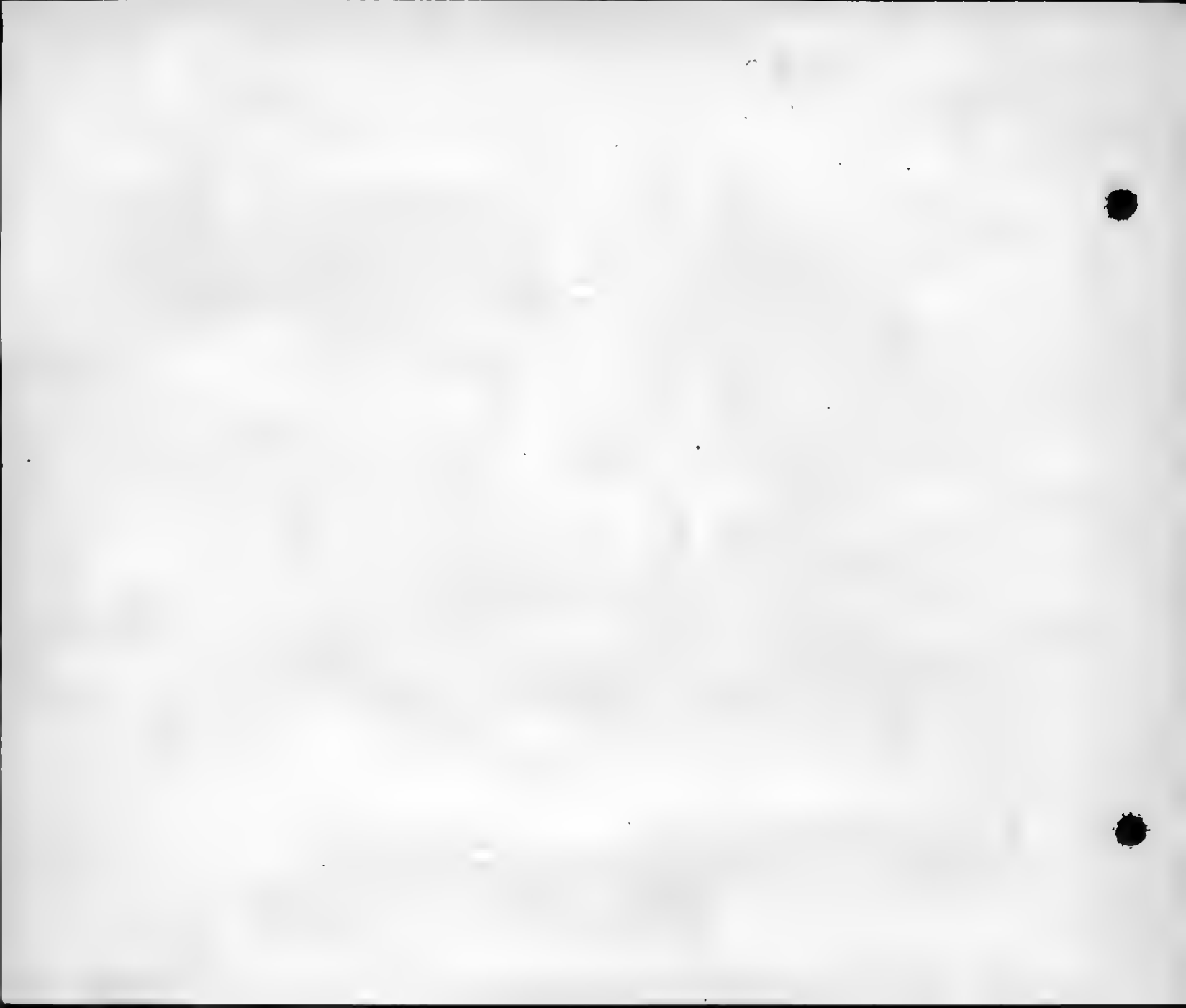
13746

13772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
c. LENGTH OF STAY IN 1b <u>1 hour</u>		d. STREET ADDRESS <u>RD 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Stanton Dailey</u>		4. DATE OF DEATH <u>December 9</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/1929</u>
9. AGE (In years last birthday) <u>30</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Finance Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry T. Dailey</u>		14. MOTHER'S MAIDEN NAME <u>Maude Travis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>WW2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mary L. Dailey</u>		Address <u>1001 Linden Lane, Willow Run, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture femur</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Ante accident</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Tractor collision</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-9-59</u> Hour <u>12:05</u> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Site 4 &amp; 1/2</u>	20f. (City or town) <u>Harford</u> (County) <u>Maryland</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u> DATE SIGNED <u>12-9-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-14-59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Md.</u>	22d. LOCATION (City, town, or county) <u>Frederick Va.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee &amp; Sons</u> ADDRESS <u>300 N. 1st St. N.E.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

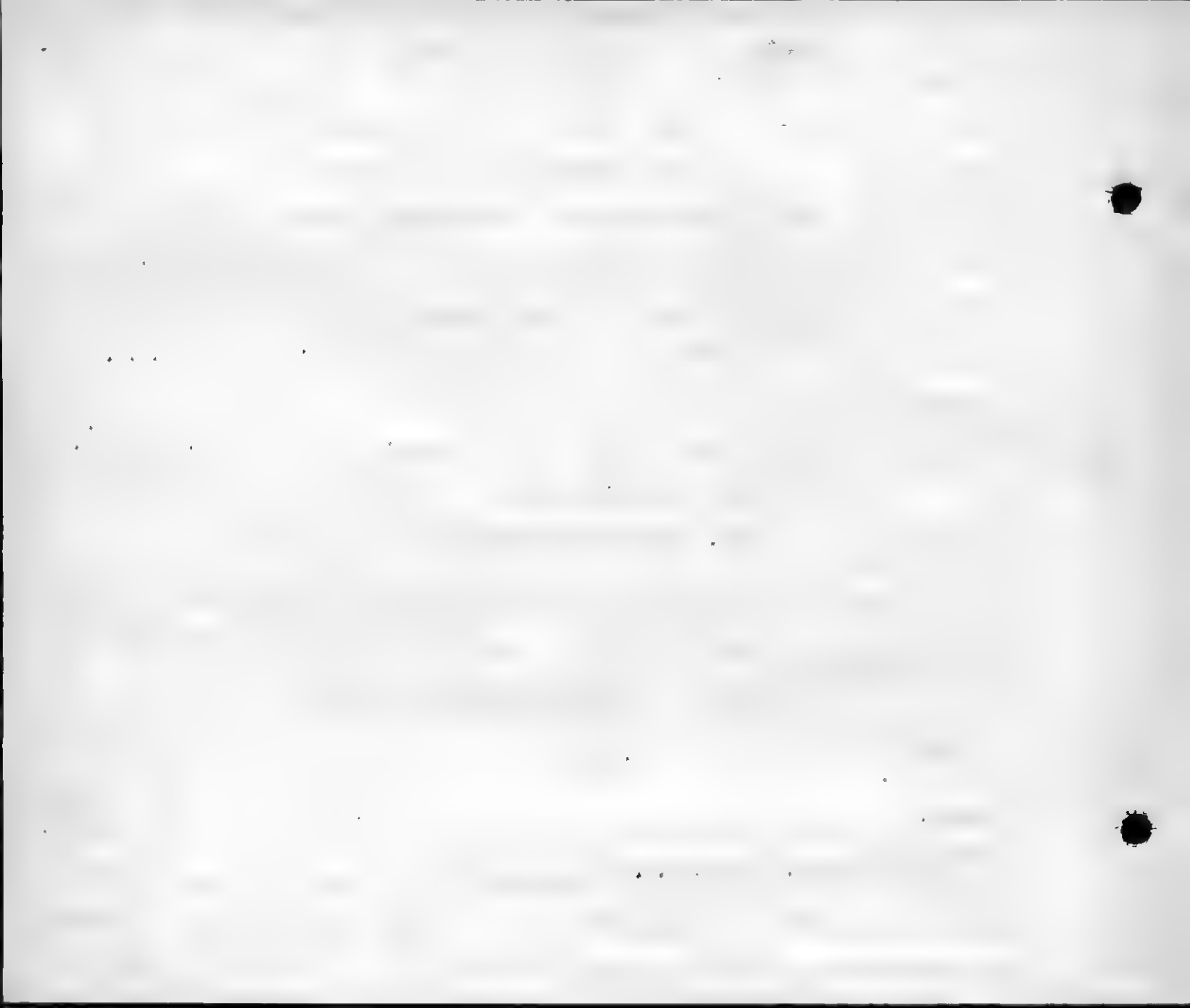
13785

## CERTIFICATE OF DEATH

Reg. Dist. No.

13747

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Bel Air</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>	
c. LENGTH OF STAY IN 1b <b>19 months</b>		d. STREET ADDRESS <b>Rock Spring Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Daughton</b>		4. DATE OF DEATH Month <b>December</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Practical</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henrey Daughton</b>		14. MOTHER'S MAIDEN NAME <b>Katherine N. Kelly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-28-3185</b>	
17. INFORMANT <b>Mrs. George E. Geyer</b>		18. ADDRESS <b>3115 Abell Ave. Balto. 18, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, terminating</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. cardiovascular-renal disease</b> DUE TO (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 1958</b> , 19____, to <b>December 24, 19 59</b> , that I last saw the deceased alive on <b>Dec. 23</b> , 19 <b>59</b> , and that death occurred at <b>9:00 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D.		<b>Forest Hill, Maryland December 26, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/28/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jarrettsville</b>	22d. LOCATION (City, town, or county) (State) <b>Jarrettsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kutz</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 29 '59</b>	
ADDRESS <b>Jarrettsville Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiser</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13786

## CERTIFICATE OF DEATH

Reg. Dist. No.

13748

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) ROCKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UPPER FALLS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>RT 24</b>		d. STREET ADDRESS <b>BRADSHAW RD.</b>	
3. NAME OF DECEASED (Type or print) <b>DAVID</b> First <b>DAVIDSON</b> Middle <b>DAVIDSON</b> Last		4. DATE OF DEATH <b>DECEMBER 9</b> 19 <b>59</b> Month <b>9</b> Day <b>9</b> Year <b>59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 18, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOARD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tool Makers</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID DAVIDSON</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA ROZETTE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-10-1329A</b>	
17. INFORMANT <b>MRS. HELEN SMITH, BEL AIR, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY 422.1</b> DUE TO <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</b> (c) <b>DIABETES SENILITY.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b> <b>3 WKS</b> <b>OVER 1 YR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES SENILITY.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JULY 6</b> , 19 <b>59</b> , to <b>DEC 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>DEC 9</b> , 19 <b>59</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>302 HICKORY</b> DATE SIGNED <b>DEC 9 1959</b>			
ACTUAL SIGNATURE <b>Philip W. Heuman</b> M.D. <b>302 HICKORY</b>			
PHYSICIAN'S NAME (Type) <b>PHILIP W. HEUMAN M.D. BEL AIR, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-12-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Salem Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Falls, Balto. Co, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Larahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>DEC 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>	



13773

## CERTIFICATE OF DEATH

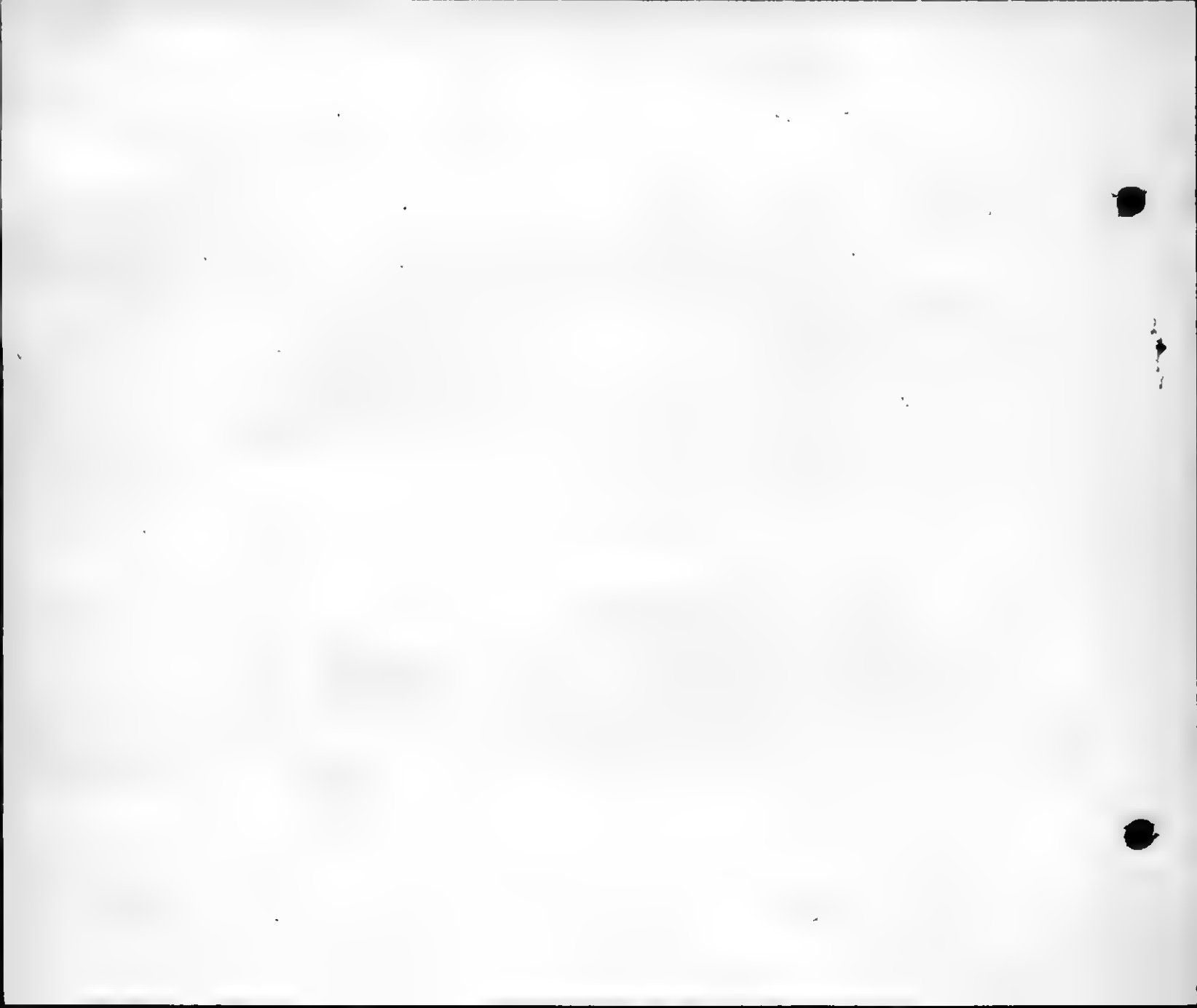
Reg. Dist. No.

13749

1 PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>15 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES BEARNARD Dayhoo, Jr</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 9 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 5-1919</b>
9. AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SAWMILL OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Dayhoo, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>ALICE BEALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>II</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <b>218-22-4913</b>	
17. INFORMANT <b>Mrs. J. B. Dayhoo</b>		<b>Bel Air Md RR</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia, rt</b> 492 ✓ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis, liver</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia bilateral chronic</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>5 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 15</b> , 19 <b>55</b> , to <b>Dec 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 9</b> , 19 <b>59</b> , and that death occurred at <b>5:50</b> M, from the causes and on the date stated above. A ADDRESS (Street, city or town, state) <b>Bel Air Md</b> DATE SIGNED <b>Dec 9 1959</b>			
ACTUAL SIGNATURE <b>J. Ralph Horkey</b> M.D.		DATE SIGNED <b>Dec 9 1959</b>	
PHYSICIAN'S NAME (Type) <b>J. Ralph Horkey MD</b>		<b>Churchville Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Dec 11/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Bel Air Harford Md Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Foster</b> ADDRESS <b>Bel Air, Md</b>		24a. REC'D BY REGISTRAR <b>DEC 14 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13750

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

13774

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>HAVRE DE GRACE</b>	c. LENGTH OF STAY IN lb <b>1 hr, 45 min.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TORT DEPOSIT, Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD MEMORIAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>ROLAND WILLARD DOWNIN JR.</b>		DATE OF DEATH <b>DEC 31 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>JUNE 1, 1944</b>	9. AGE (In years last birthday) <b>15 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HIGH SCHOOL</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>ROLAND W. DOWNIN SR.</b>		14. MOTHER'S MAIDEN NAME <b>ROBERTA EBERHARDT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>ROLAND DOWNIN SR. (SAME)</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 45 min</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BASAL SKULL FRACTURE C</b> DUE TO <b>CONTUSION AND CONCUSSION BRAIN</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY AND CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>AUTO ACCIDENT ROLLED AUTO OVER</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:15 a.m. DEC 31 1959</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HIGHWAY</b>	20f. (City or town) (County) (State) <b>RISING SUN, CECIL MD</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		DATE SIGNED <b>DEC 31, 1959</b>	
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN MD.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-3-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Colora, Md. Rural</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>		24a. REC'D BY REGISTRAR <b>Perryville, Md.</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. ...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 13775 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No. 13751

1 PLACE OF DEATH a. COUNTY <u>Hartford.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Luther Eggers</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>19 59</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-59</u>
9. AGE (in years last birthday) yrs <u>7</u>		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>New born</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LUTHER EGERS</u>		14. MOTHER'S MAIDEN NAME <u>REMA SPRADLING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*** **</u>	
17. INFORMANT <u>Luther Eggers</u>		Address <u>213 N. Union</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antepartum &amp; intra partum</u> DUE TO <u>uterine infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uterine infection</u> DUE TO (c) <u>uterine infection</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/20/59</u> , 19 <u>59</u> , to <u>12/20/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/20/59</u> , 19 <u>59</u> , and that death occurred at <u>5:00 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard Normont</u> M.D.		DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>Richard Normont, M.D.</u>		ADDRESS (Street, city or town, state) <u>602 S. Union Ave. Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grove Presbyterian</u>	22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Garvey - Chesapeake</u>		ADDRESS <u>Chesapeake</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

10. 3. 1961

10. 3. 1961

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13776 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13752

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Trace</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>129 Union Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William C. Gerard</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/1896</u>
9. AGE (in years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Columbian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kellogg Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank G. Gerard</u>		14. MOTHER'S MARDEN NAME <u>Rosalie Shanche</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Adrian D. Shanche</u>		Address <u>111 N. Union Ave, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltair, Md</u> DATE SIGNED <u>12-20-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/23/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington</u>		ADDRESS <u>Pennington, Hanover Trace, Md.</u>	
24a. REC'D BY REGISTRAR <u>29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13787

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13753

1. PLACE OF DEATH a. COUNTY <u>Hagerstown</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>4 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Road</u>				d. STREET ADDRESS <u>100 E. Frederick Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Earl Hamm</u>				4. DATE OF DEATH <u>Dec. 12</u> 19 <u>59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-31</u>	9. AGE (In years last birthday) <u>28</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Rich. Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Austin Hamm</u>				14. MOTHER'S MAIDEN NAME <u>Susan Caroline Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean War</u>		16. SOCIAL SECURITY NO. <u>325-34-2011</u>		17. INFORMANT <u>Wannie Lee Hamm</u> Address <u>Mockton Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compound, comminuted fracture skull</u> 812X DUE TO <u>with evulsion of brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>into accident auto pedestrian</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a. m. <u>12</u> p. m. <u>11</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>road</u>		20f. (City or town) <u>Frederick</u> (County) <u>Frederick</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Donald P. Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Donald P. Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Independence</u>		22d. LOCATION (City, town, or county) <u>Independence Virginia</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Kutz</u> ADDRESS <u>Farmingtonville Md.</u>				24a. REC'D BY REGISTRAR <u>Charles C. Kutz</u> DATE <u>DEC 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles C. Kutz</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No. 13754

13788

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>2 Wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 S. Main St.</u>		d. STREET ADDRESS <u>118 S. Main St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Barbara</u> Middle <u>Hawks</u> Last <u>Hawks</u>		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2 1952</u>
9. AGE (In years last birthday) yrs. <u>11</u> Months <u>13</u> Days <u>13</u> Hours <u></u> Min <u></u>		10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Darwin Hawks</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Bare</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Darwin Hawks</u>		Address <u>Bel Air, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>495X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 22, 1959</u> to <u>Dec 22, 1959</u> , that I last saw the deceased alive on <u>Dec 22, 1959</u> , and that death occurred at <u>10 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>12-22-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon E. Miller</u> ADDRESS <u>Rising Sun Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Travis</u>

2071161XU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

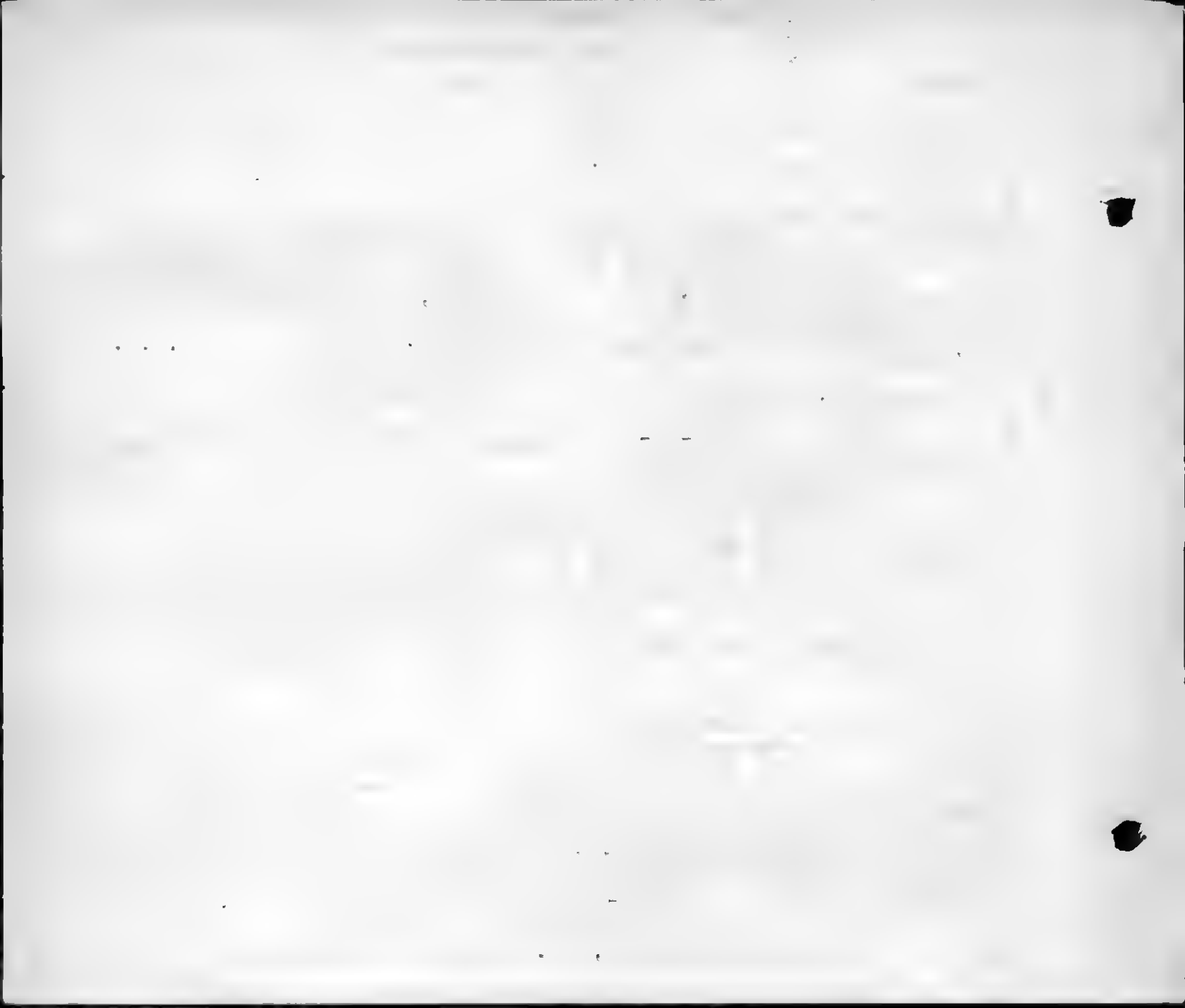
Item 18 File 1-5-60 ams

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 13755

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>31 hrs.</u>		d. STREET ADDRESS <u>13 Rogers St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Halward Johnson</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 11, 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Bank, &amp; Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel M. Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Caroline Nowland</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>218-12-2975</u>		17. INFORMANT <u>Theodore Cooke Long</u> Address <u>Bar Harbor, Me.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure; Atherosclerotic Heart Disease</u> <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture, Left Femoral Neck [FEMUR]</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>12-17</u> , 19 <u>59</u> , to <u>12-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-18</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Frank D. Hauber</u> M.D.		608 South Union Ave., Harford, Md.	
PHYSICIAN'S NAME (Type) <u>Frank D. Hauber, M.D.</u>		12/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North-East Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>North East, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13757

13778

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>—</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01 4.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>411 Park Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Cecilia Eleanor Menger</u> First Middle Last		4. DATE OF DEATH <u>December 15</u> 195 <u>9</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry work (ret'd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lord Balto. Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Barry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bennett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-03-2191</u>	
17. INFORMANT <u>Mrs. Catherine Brannan, Joppa, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>—</u> DUE TO <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident - auto</u>	
20c. TIME OF INJURY Month, Day, Year <u>7</u> <u>12-15-59</u> Hour <u>—</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>etc. 40</u>		20f. (City or town) <u>Joppa</u> (County) <u>Harf</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Ed A. H.</u> DATE SIGNED <u>12-16-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer-MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13756

1. PLACE OF DEATH a. COUNTY <u>Hairford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmedo Trace</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Liberty Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DCA Hairford Memorial Hospital</u>		e. STREET ADDRESS <u>0. X-2</u>	
3. NAME OF DECEASED (Type or print) <u>Rosemarie Baby Boy Moulton</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1959</u>
9. AGE (in years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert M. Moulton Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Stella Faye Wyatt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert M. Moulton Jr., Liberty Grove, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aspiration vomitus</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>David C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bellair, Md</u> DATE SIGNED <u>12-26-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-28-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Bridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Coloma, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>		ADDRESS <u>Perryville, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Lee A. Patterson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13789

## CERTIFICATE OF DEATH

Reg. Dist. No.

13758

1 PLACE OF DEATH a COUNTY <u>Harford</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingman Harbor</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingman Harbor</u> d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Harford</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingman Harbor</u> d STREET ADDRESS e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Margaret M. Page</u> First Middle Last 4 DATE OF DEATH <u>12/5/59</u> Month Day Year		5 SEX <u>Female</u> 6 COLOR OR RACE <u>White</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>3/30/1874</u> 9 AGE (In years, lost birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>W. Va. Holly N.J.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Martin J. Brady</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Power</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Margaret M. Lettinger, Neshaminy, Pa</u> Address <u>501 Chaucer Road</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Circulatory Failure</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>17 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-6-</u> , 19 <u>58</u> , to <u>12-5-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-5-1959</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, City or town, State) <u>8 LAW ST. Aberdeen, Md.</u> DATE SIGNED <u>8</u>			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D. PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/9/59</u> 22b. DATE THEREOF <u>St. Marys</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u> 22d. LOCATION (City, town, or county) (State) <u>W. Va. Holly N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conroy &amp; Son, Harford Co., Md</u> ADDRESS <u>Conroy &amp; Son, Harford Co., Md</u> 24a. REC'D BY REGISTRAR <u>DEC 10 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
13790		14367	
1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Mercy</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Edgewood Rt. 40</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trenton</b>	
c. LENGTH OF STAY IN MD		d. STREET ADDRESS <b>219 E. Hanover</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <b>JEREMIAH</b> (Type or print)	First	Middle	Last
5. SEX <b>Male</b>	6. COLOR OR RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1934</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home const.</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Sidney Patrick</b>	14. MOTHER'S MAIDEN NAME <b>Della Wilson</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>250-54-3170</b>	17. INFORMANT <b>Vernee Floyd</b>	Address <b>Trenton, N.J.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>and</b> (c) <b>second and third degree body burns</b> DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto-bus accident</b>		
20c. TIME OF INJURY Month, Day, Year <b>10:00 a.m. Dec. 25 1959</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>Edgewood</b> (County) <b>Harford</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <b>Charles S. Petty</b>		DATE SIGNED <b>12/26/59</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-30-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Conway Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Conway S.C.</b>	
23. FUNERAL DIRECTOR <b>McKiener Funeral Home</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Petty</b>	
1408 Race Path Ave., Conway, S. C.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

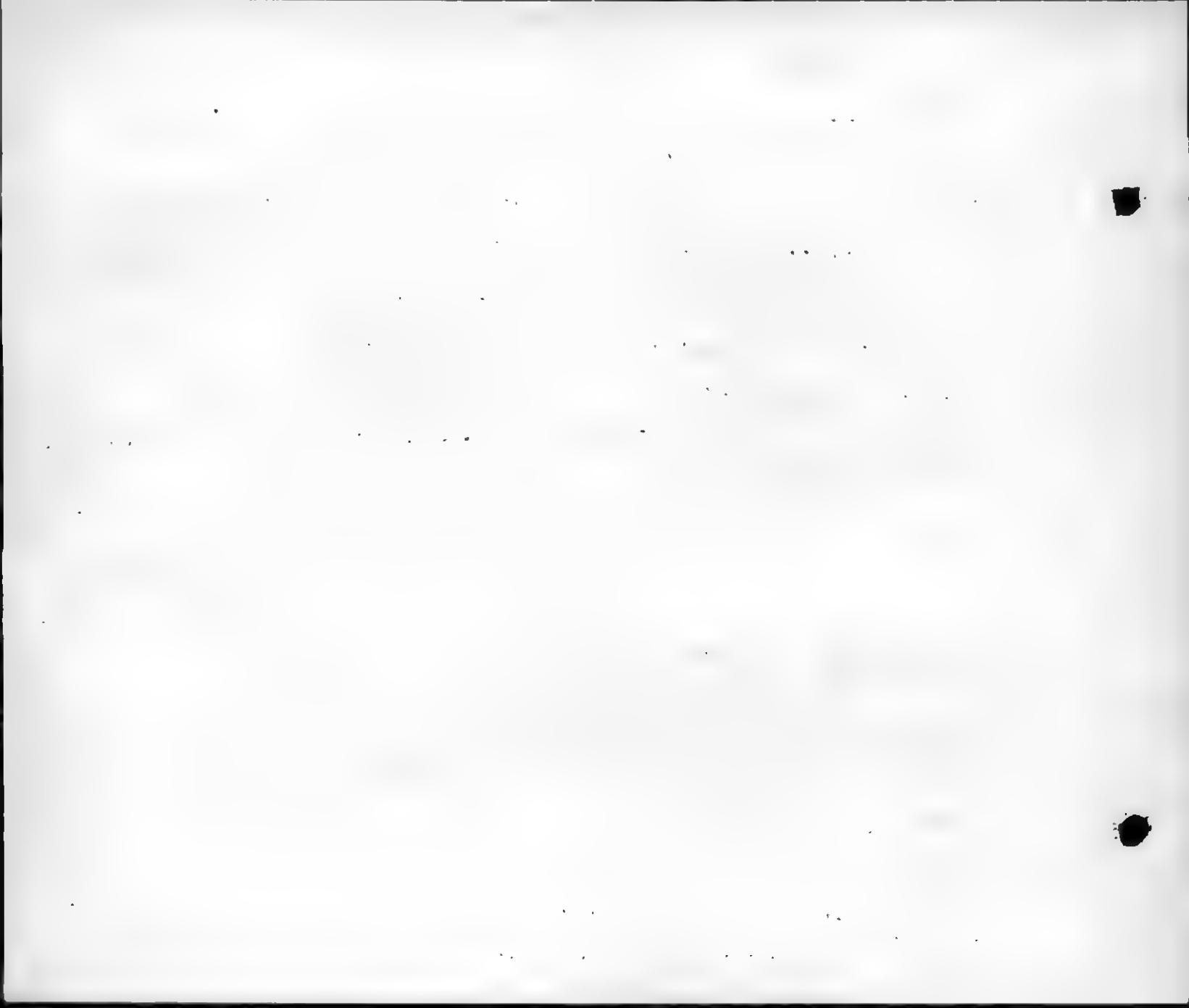
Item 4, telephone call-Lassahn Funeral Home 12/24/59, acc.

13791

## CERTIFICATE OF DEATH

Reg. Dist. No. 13753

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JOPPA MD.</b>				c. LENGTH OF STAY IN 1b <b>10 YEARS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT. 1. Box 252A JOPPA MD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES WILLIAM RASPE</b>				4. DATE OF DEATH Month Day Year <b>December 17 19 59.</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 17, 1889</b>	
9. AGE (In years last birthday) <b>70 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN H RASPE JR.</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET RAVADGE.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-8007</b>		17. INFORMANT Address <b>MRS CHARLES RASPE RT. 1. Box 252A JOPPA MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal tumor (left kidney) with metastases to lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>180 X</b> DUE TO (c) <b>12 months.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-30</b> , 19 <b>54</b> , to <b>12-17-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-16</b> , 19 <b>59</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edgewood, Md 12-18-59</b>							
ACTUAL SIGNATURE <b>Fred O. Hodous</b> M.D. <b>Edgewood, Md</b>							
PHYSICIAN'S NAME (Type) <b>Fred O. Hodous</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC 19, 1959.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>JERUSALEM.</b>		22d. LOCATION (City, town, or county) (State) <b>JOPPA MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Lassahn Funeral Home 7401 Belair Rd #7</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





## CERTIFICATE OF DEATH

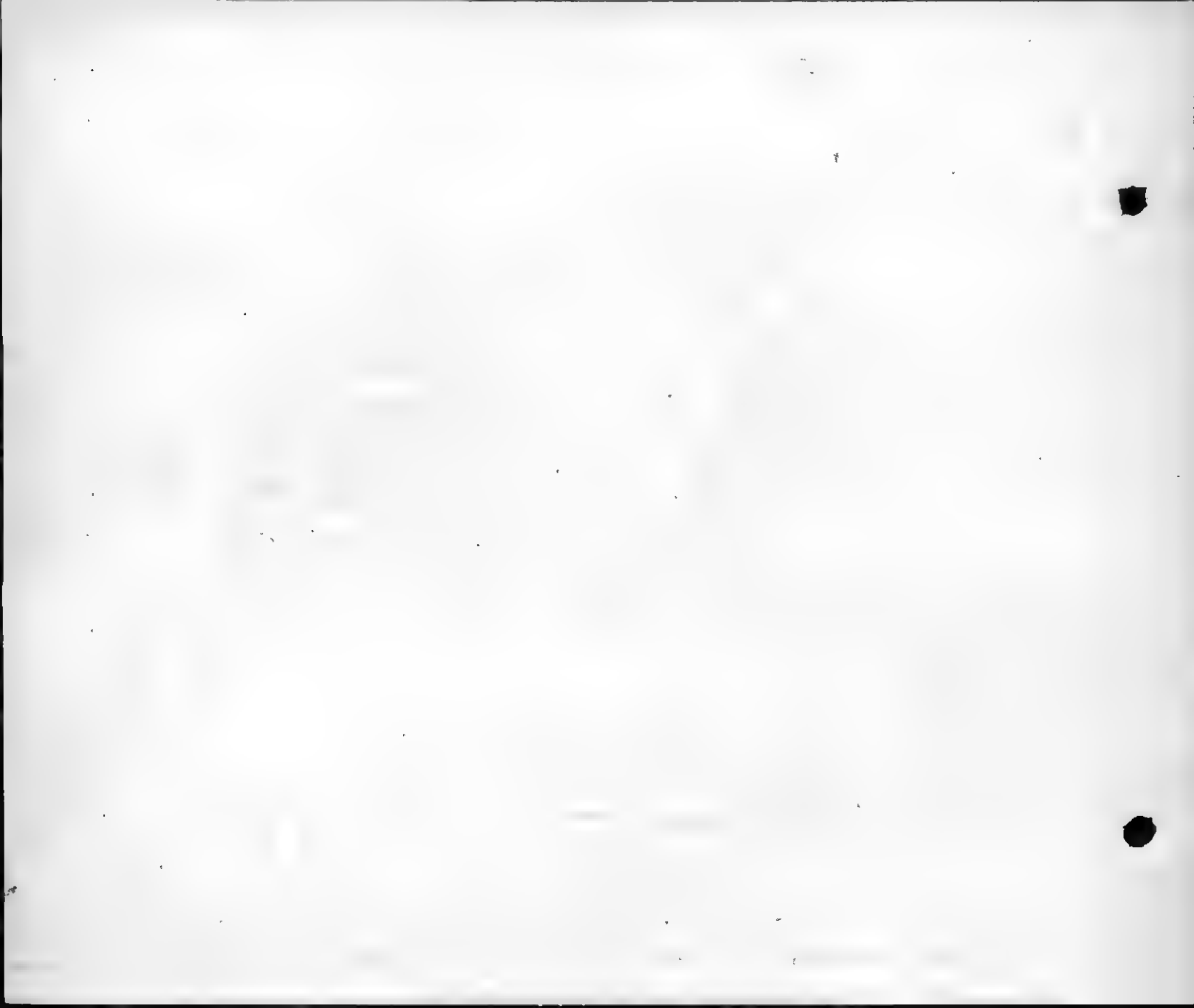
13760

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i> c. LENGTH OF STAY IN 1b <i>03X-2</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dorford Memorial Hospital</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Arm</i> d. STREET ADDRESS <i>Glen Arm Box 608</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Agnes</i> Middle <i>T</i> Last <i>Reamy</i>		4. DATE OF DEATH Month <i>December</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-17-86</i> <i>Maryland</i>
9. AGE (In years last birthday) <i>13</i> yrs		10. IF UNDER 1 YEAR Months <i>13</i> Days <i>13</i> Hours <i>13</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland (Baltimore)</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Frank Martin</i>		14. MOTHER'S MAIDEN NAME <i>Mary Doyle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Julian A. Reamy - same - husband</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Blood Loss Shock</i> DUE TO <i>Ruptured Abdominal Aorta</i> (b) <i>Aneurysm</i> DUE TO <i>Aneurysm</i> (c) <i>Aneurysm</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i> <i>2-3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>451X</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>35</i>		20f. (City or town) <i>12/27/1959</i> (County) (State)	
21. I certify that I attended the deceased from <i>2:35 AM</i> to <i>1:15 PM</i> , that I last saw the deceased alive on <i>12/27</i> , 19 <i>59</i> , and that death occurred at <i>1:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. H. Sadowsky</i> M.D. <i>504 LEWIS ST.</i>		DATE SIGNED <i>12/27/59</i>	
PHYSICIAN'S NAME (Type) <i>W. H. SADOWSKY</i>		<i>Harre de Grace, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12-30-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Long Green, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook, Inc., 1217 St. Paul Street</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

13792 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14368

1. PLACE OF DEATH  
a. COUNTY Harford MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood Rt. 40  
c. LENGTH OF STAY IN MD  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE New Jersey b. COUNTY Mercy  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Trenton  
d. STREET ADDRESS 632 Princeton Ave

3. NAME OF DECEASED (Type or print) First Middle Last  
HENRY L. RIGGINS  
4. DATE OF DEATH Month Day Year  
December 25 1959

5. SEX Male 6. COLOR OR RACE C. 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH  
Oct. 1935 9. AGE (In years last birthday) 24 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dish Washer 10b. KIND OF BUSINESS OR INDUSTRY Hotel 11. BIRTHPLACE (State or foreign country) South Carolina 12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Glennie Riggins 14. MOTHER'S MAIDEN NAME Alice Mc Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Vernee Floyd Trenton N.J. Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning  
DUE TO and  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) second and third degree body burns  
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18) Auto-bus Accident

20c. TIME OF INJURY Month. Day. Year 10:00 Dec 25 1959 20d. INJURY OCCURED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Edgewood (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

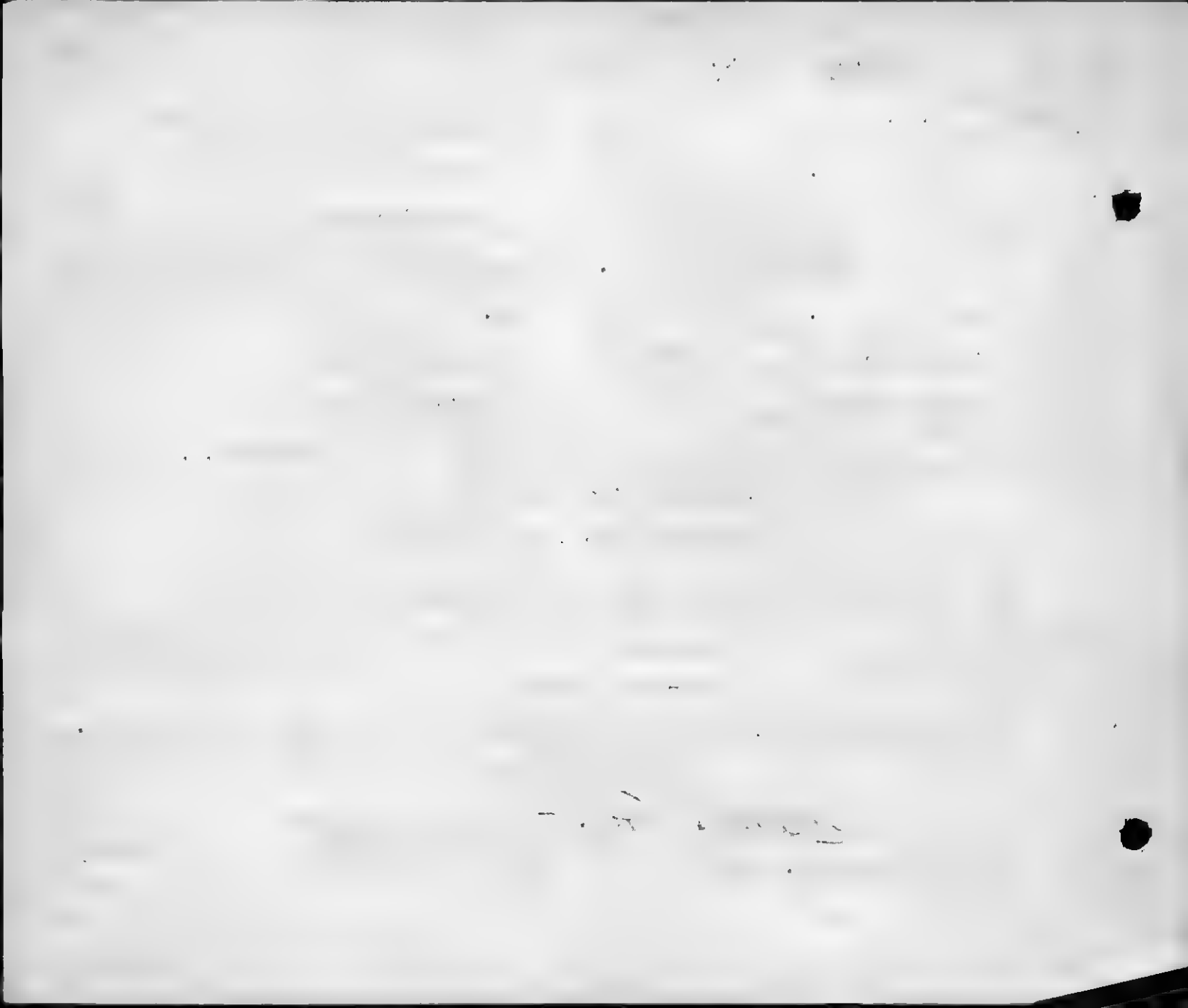
ACTUAL SIGNATURE Charles S. Petty M D CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED 12/26/59

EXAMINER'S NAME (Type) Charles S. Petty Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 12-30-59 22c. NAME OF CEMETERY OR CREMATORY Conway Cem 22d. LOCATION (City, town, or country) (State) Conway S.C.

23. FUNERAL DIRECTOR McHenry Funeral Home ADDRESS 1408 Race Path Ave., Conway, S.C. 24a. REC'D BY REGISTRAR JAN 7 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1408 Race Path Ave., Conway, S.C.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13793

CERTIFICATE OF DEATH

Reg. Dist. No.

13761

1 PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EMMORTON</u>				c. LENGTH OF STAY IN 1b <u>35 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgewood Rd. Box 381</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Constance</u> Middle <u>Poor</u> Last <u>Stump</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3-1899</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>	
13. FATHER'S NAME <u>HENRY W. POOR</u>				14. MOTHER'S MAIDEN NAME <u>Constance BRAYDON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-22-1468</u>		17. INFORMANT <u>John W. Stump</u> Address <u>Edgewood Rd. Box 381</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO <u>Carcinoma of esophagus.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>spreading to lymphatic system</u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April</u> , 1959 to <u>Dec. 13</u> , 1959, that I last saw the deceased alive on <u>Dec. 13</u> , 1959, and that death occurred at <u>11:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Charles Richardson M.D.</u>				DATE SIGNED <u>Bel Air, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>EMMORTON Hartford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>				ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>							



13781

## CERTIFICATE OF DEATH

Reg. Dist. No.

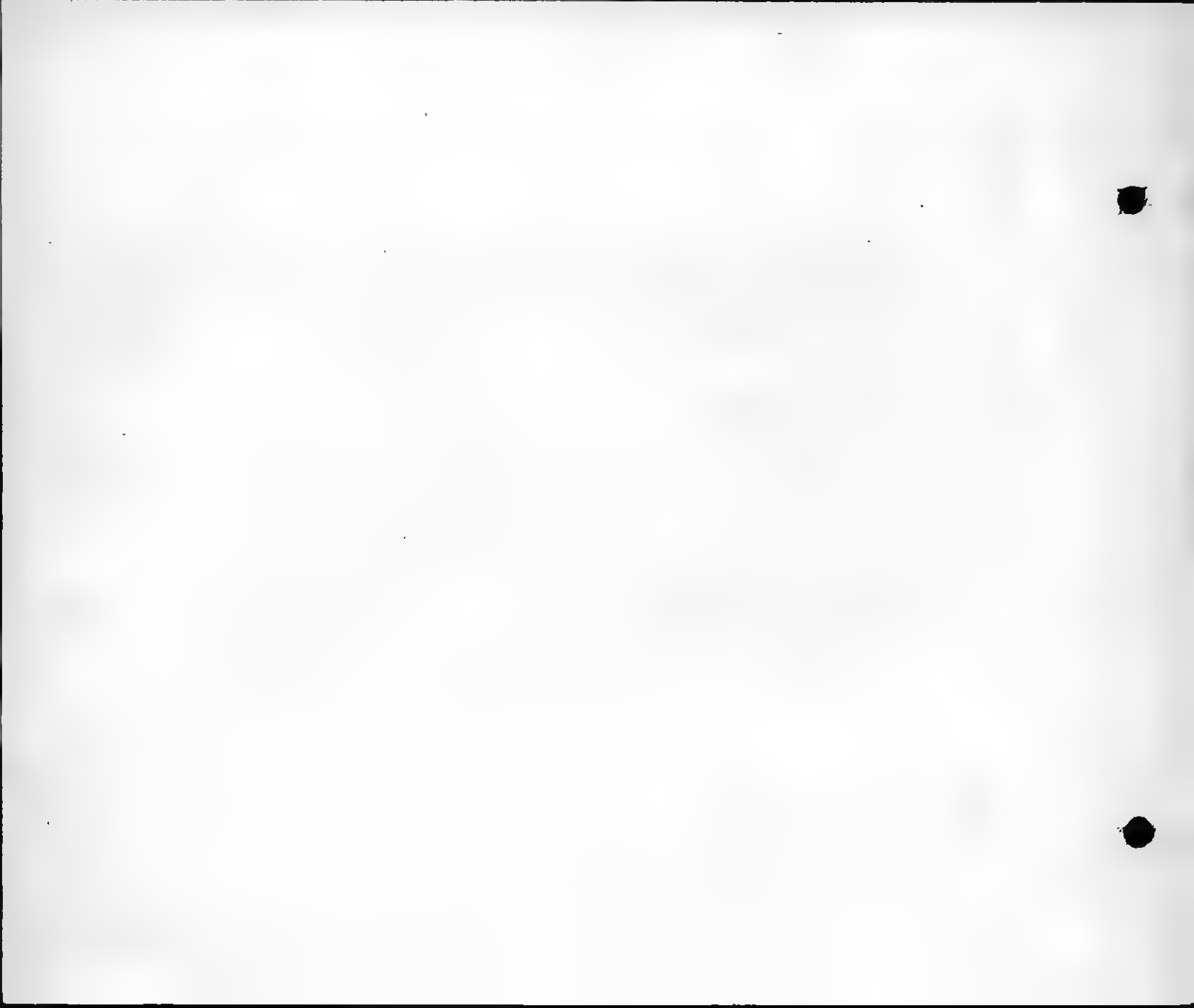
13762

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAUCE DE GRACE</b> c. LENGTH OF STAY IN lb <b>Rising SUN</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rising SUN</b> d. STREET ADDRESS <b>Rising Sun</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRED EDWARD SUTPHIN</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 21 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-17-1905</b>
9. AGE (in years last birthday) <b>54 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emmett Sutin</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Kemp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-07-686</b>	
17. INFORMANT <b>Harry E. Sutin</b>		Address <b>Rising Sun, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>237X</b> DUE TO <b>Cerebrovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Poss brain tumor</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>48 hr</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/17</b> , 19 <b>59</b> , to <b>12/21</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12/21</b> , 19 <b>59</b> , and that death occurred at <b>3:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md</b> DATE SIGNED <b>12/21/59</b> ACTUAL SIGNATURE <b>Neil Fough</b> M.D. PHYSICIAN'S NAME (Type) <b>Neil Fough</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
ADDRESS <b>North East Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13782

## CERTIFICATE OF DEATH

Reg. Dist. No.

13763

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before adm ssion) b. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>15 HOURS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>TUCKER</u>		4 DATE OF DEATH Month <u>DEC</u> Day <u>20</u> Year <u>1959</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>DEC 20, 1959</u>
9 AGE (In years last birthday) <u>one day</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	IF UNDER 24 HRS Hours <u>15</u> Min <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11 BIRTHPLACE (State or foreign country) <u>HARFORD HOSP. MARYLAND</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JAMES STERLING TUCKER</u>	
14. MOTHER'S MAIDEN NAME <u>DOROTHY ANN CARLILE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>PREMATURITY (28 weeks) f.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVA. BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 20</u> , 19 <u>59</u> , to <u>Dec 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andre Weiss</u> M.D.		ADDRESS (Street, city or town, state) <u>114 W. Bel Air Ave</u> DATE SIGNED <u>Hardeen, Md</u>	
PHYSICIAN'S NAME (Type) <u>ANDRE WEISS M.D.</u>			
22a. <del>DATE</del> CREMATION, REMOVAL <input checked="" type="checkbox"/>	22b. DATE THEREOF <u>12-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Hardeen, Maryland</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Henry R. Zuby Administrator</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>DEC 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13783**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **13764**

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVE DE GRACE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3401-4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hospital</b>				e. STREET ADDRESS <b>3117 Presbury St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>Thomas</b> Last <b>WATTS</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>23</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 28</b> <b>VIRGINIA</b> 1904		9. AGE (In years last birthday) <b>55</b> yrs.	10. IF UNDER 1 YEAR: Months <b>5</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia, Prince Edward county</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARLAND WATTS</b>				14. MOTHER'S MAIDEN NAME <b>Mildred Walker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>705-10-3125</b>		INFORMANT <b>Mrs Ida S. Watts</b>		Address <b>3117 Presbury St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular - renal disease</b> DUE TO (c) <b>disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Since 11/20/59</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Nov. 20th, 1959</b> to <b>Dec. 23rd, 1959</b> that I last saw the deceased alive on <b>Dec. 23rd, 1959</b> and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward C. Foo</b> M.D.				ADDRESS (Street, city or town, state) <b>211 N. Union Ave. Harve de Grace, Md.</b>		DATE SIGNED <b>12/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert E. Nutter</b>				ADDRESS <b>3810 Bonner Rd</b>		24a. REC'D BY REGISTRAR <b>DEC 29 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u> c. LENGTH OF STAY IN 1b <u>28 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARTFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>241 HAVERDE GRACE</u> d. STREET ADDRESS <u>Box 1 OLD POST ROAD</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LETTIE</u> Middle <u>RUTH</u> Last <u>ZELLMAN</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 14, 1914</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT G. HALL</u>		14. MOTHER'S MAIDEN NAME <u>LAURA B. ROBERTS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
INFORMANT <u>FREDERICK A. ZELLMAN</u>		Address <u>HAVERDE GRACE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple pulmonary emboli</u> 171X DUE TO <u>Carcinoma of Cervix - with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c) <u>metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MAKNUTRITION, RENAL SHUTDOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 15, 1959</u> , to <u>December 22, 1959</u> , that I last saw the deceased alive on <u>December 18, 1959</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond J. Donovan, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>200 N. Union Ave. Haverde Grace Md.</u>	
PHYSICIAN'S NAME (Type) <u>RAYMOND J. DONOVAN, JR.</u>		DATE SIGNED <u>12-22</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 26, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK RON</u>		22d. LOCATION (City, town, or county) (State) <u>HARTFORD CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madson Mitchell</u>		ADDRESS <u>Haverde Grace Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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